CORONAVIRUS DISEASE 2019 (COVID-19)

Social Health Playbook

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Introduction and Purpose

Background

Kaiser Permanente has long understood that being healthy is not just a result of high-quality medical care. Total health depends on having a safe place to live, nourishing meals to eat, meaningful social connections, and many other essentials.

During the COVID-19 global pandemic, our responsibility to care for people's social well-being is more evident than ever. We know from surveying 10,000 Kaiser Permanente members in 2020 that 63% of people had at least 1 social factor they needed help with. Many people had more. Additionally, people of color experienced the need for support disproportionately more than our white members. For example, African American Kaiser Permanente members were nearly 4 times more likely to experience transportation issues compared to white members. Hispanic members were more than twice as likely to experience food insecurity than white members.

COVID-19 continues to expose stark health inequities in our communities, and as our country confronts the myriad impacts of structural racism, Kaiser Permanente is committed to being part of the solution. This playbook provides guidance on how to incorporate social health practices into the provision of care, so no one is left behind. The playbook was developed initially as an internal resource, and we have adapted it to share with others in the field to expand the health sector's ability to improve people's social health during the current COVID-19 global health crisis and beyond.

Purpose

The social health playbook provides guidance on caring for patients with social needs within a COVID-19 context. It includes information on how to identify social factors impacting patients' overall health, connect them to resources to address those factors, and follow up to ensure their needs were met, coordinating additional care as appropriate.

Additional considerations are included for seniors, those with behavioral health needs, and victims of intimate partner violence (IPV).

Target population

Since most patients have social factors impacting their health, the target population for social health practices is broad. Specifically, the information in this playbook can support patients under investigation of COVID-19 and patients with confirmed cases of COVID-19 who are in a care delivery setting.

Future versions

This playbook was adapted from an internal resource and will be refreshed over time.

How to Use this Playbook

Users

The intended users of this playbook are frontline staff or other care team members performing care coordination, care management, care continuum, or similar functions. Both clinical and non-clinical staff can implement these action steps.

Facilitating use of playbook

The use of the playbook should be facilitated by a clinic leader(s) in charge of care coordination, care management, care continuum, or a similar care delivery function. Prior to implementation, the leader should adapt the contents to ensure alignment with organizational and community resources. Key decisions and issues to address:

+ Determine the applicable screening or assessment tool or module to use.

+ Develop and implement training protocols for care coordinators, patient navigators, discharge planners, etc.

+ Partner with community-based organizations and public agencies.

How this playbook is organized

The playbook is organized around a 3-step process recommended for supporting patients who have social factors affecting their health. You can use these 3 steps (screen, connect, follow up) to quickly navigate the material in the playbook and to take action to help patients needing social and behavioral health support.

Chapter 1	Purpose and overview.
Chapter 2	Guidance on **screening** and special considerations for screening in the **virtual setting**. Specialized information for screening patients experiencing: • homelessness • food insecurity • social isolation • financial strain • intimate partner violence
Chapter 3	How to **connect** patients to resources. Specific guidance included for working with patients experiencing: • homelessness • food insecurity
Chapter 4	Suggestions on **following up** to make sure patients' needs are met
Chapter 5	Focused content relevant to patients with **behavioral health needs** – from screening, connection to resources, and following up.
Chapter 6	Additional information about community-based services and organizations, organized by state, social need, and listed separately for seniors: • homelessness • housing instability • food insecurity • social isolation • financial strain • digital access • seniors

Social Needs and COVID-19: Preventing Further Transmission and Addressing Related Issues

People with unmet social needs are likely to suffer the greatest impact from COVID-19. Additionally, as the pandemic stretches on, people are experiencing new challenges due to the related economic uncertainties.

Homelessness and housing instability

Many people experiencing homelessness are older, are in poor health, receive care and services in congregate settings (e.g., shelters, soup kitchens), and have limited ability to access or follow public health advice (e.g., frequent hand washing), making them especially susceptible to the COVID-19 virus. People experiencing homelessness are twice as likely to be hospitalized for COVID-19, up to 4 times as likely to require critical care, and 2-to-3 times more likely than a stably housed patient to die.[1] Addressing their social circumstances, such as access to proper shelter and food, not only ensures appropriate care is provided to this very vulnerable population, but also helps prevent further transmission of the virus. For these same reasons, it is important to protect people experiencing housing instability from losing their homes.

Food insecurity

The number of people who are food insecure has increased due to the economic downturn and stay-at-home policies resulting from COVID-19. Food insecurity is a risk to health, and people with diet-related conditions like diabetes and cardiovascular disease are at greater risk for complications from COVID-19.[2]

Social isolation

The physical distancing required to prevent the spread of COVID-19 is likely to increase social isolation and loneliness, which are associated with a significantly increased risk for early death from all causes.[3] On the other hand, distancing from people outside of one's household can lead to sustained crowding and social tension within households, leading to other concerns such as intimate partner violence and child abuse. Major life changes such as loss of a spouse, loss of a social network as a result of becoming a parent, and the impacts of the pandemic contribute to feelings of social isolation and/or loneliness for people of all ages. People who were at risk for social isolation and/or loneliness before the pandemic are especially at risk of adverse health consequences, especially if they are not an active user of digital technology. Additionally, individuals who are socially isolated and without strong social networks might need more help addressing their basic needs, such as procuring food in such a way that prevents further transmission of the virus.

Financial strain

The shelter-in-place and stay-at-home orders put in place to slow the spread of COVID-19 have negatively impacted the economy. As a result of the spike in unemployment and loss of income, many are experiencing financial strain in the form of inability to pay for essentials like housing, food, and health care coverage and services. Addressing these various factors will support improved health outcomes for patients, prevent their circumstances from worsening, and prevent further transmission of the virus.

[1] Dennis Culhane, Dan Treglia & Ken Steif. Randall Kuhn, Thomas Byrne. Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality. University of Pennsylvania; University of California Los Angeles; Boston University. March 25, 2020

[2] Certain medical conditions and risk for severe covid-19 illness. 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

[3] National Academies of Sciences, Engineering, and Medicine. 2020. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. https://doi.org/10.17226/25663

Digital access

Digital technology is a necessity for many households, with some making the case that digital access, or the lack thereof, should be recognized as a social determinant of health.[4]

Lack of access to broadband internet service, particularly during the COVID-19 pandemic, negatively impacts the health of our most vulnerable populations. It can restrict ability to both find employment and work remotely; participate in remote schooling; access grocery and food-delivery services; and participate in virtual groups that provide social, religious, and supportive services

In the health care system domain, it is estimated that 1-in-4 in Americans do not have broadband internet access or devices needed to engage in medical video visits.[5] Lack of broadband internet access limits not only synchronous video care consultations, but also patient/provider messaging and remote device monitoring (such as blood pressure).[4]

The presence and use of computers have increased over time, however access is not equal across all groups. Adults over age 65 have lower computer use and broadband subscriptions. Among Blacks (non-Hispanic) and Hispanics (any race), smartphone usage is more prevalent than laptop, desktop, or tablet usage, with those groups less likely to have broadband internet subscriptions. Among adults with less than a high school degree, only a small percentage have access to the internet. Those who live in non-metropolitan/rural areas are limited in the use of technology due to broadband access connectivity issues. Additionally, those whose household incomes are less than $25,000 report lower level of technology usage. In summary, digital inequality impacts people who are older, Black and/or Hispanic, have less formal education, and have lower incomes.[6]

Factors contributing to these barriers vary and include, but are not limited to, cost of internet access, availability of service, cost of device, internet accessed outside of home, building/housing unit not wired, not comfortable or interested in using computers, and digital literacy.

Vulnerable populations: Seniors

Sixteen percent of Americans are 65 years and older[7] and are more likely to have underlying health conditions that make it harder to cope with and recover from illness. Meanwhile, even without physical distancing, a University of California San Francisco (UCSF) study[8] showed 43% of those 65-years and older experience feelings of loneliness. Due to the COVID-19 pandemic, loneliness is likely to be even higher due to the physical distancing and limited social contacts seniors are being encouraged to undertake. Also, seniors, who represent a higher percentage of nursing home or long-termcare facility residents, are at higher risk for loneliness and developing health conditions. As elderly people are being instructed to remain at home, have groceries and vital medications delivered, and to avoid social contact with family and friends, they are more likely to face mental and physical health consequences. And seniors might be expected to stay sheltering in place and physical distancing for longer than the younger population, so their risk for social isolation and loneliness could be further augmented. As such, it is important to assess their levels of loneliness and access to medical services.

[4] Benda, N., Veinot, T., Sieck, C., & Ancker, J. (2020). Broadband Internet Access Is a Social Determinant of Health! American Journal of Public Health, 110(8), 1123–1125. https://doi.org/10.2105/ajph.2020.305784

[5] Nouri, S., Khoong, E. C., Lyles, C. R., & Karliner, L. (2020). Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic. Nejm Catalyst Innovations in Care Delivery. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7371279/

[6] File, T. (2013). Digital Divides: A Connectivity Continuum for the United States. United States Census Bureau.

[7] Statista. (2021, January 20). U.S. - seniors as a percentage of the population 1950-2050. https://www.statista.com/statistics/457822/share-of-old-age-population-in-the-total-us-population/

[8] Perissinotto, C. M., Stijacic Cenzer, I., & Covinsky, K. E. (2012). Loneliness in Older Persons. Archives of Internal Medicine, 172(14), 1078–1083. https://pubmed.ncbi.nlm.nih.gov/22710744/

Vulnerable populations: Those with behavioral health conditions

Amid the COVID-19 pandemic, people with behavioral health conditions are particularly at risk. The behavioral effects of COVID-19 are as important to address as the physical health effects. Fear, anxiety, and depression in response to the emergency are normal for those without any diagnoses, meanwhile, the effect compounds symptoms for those with such diagnoses. And for the 1-in-5 people who already have mental health conditions, or the 1-in-2 who are at risk of developing them, it is critical that we focus on this very vulnerable population.[9] An April 2020 Lancet[10] article identified that those in China during the COVID-19 pandemic with a behavioral health condition were more susceptible and more likely to develop an infection (including pneumonia). They were more likely to transmit the virus due to congregation in care settings, and, with quarantine measures in place, were more apt to receive no care for their behavioral health conditions. As such, it is imperative that care teams be aware of how patients with behavioral health conditions are functioning, including how closely they are connected to social support, and any potentiality for suicide or self-harm.

Vulnerable populations: Victims of intimate partner violence (IPV), child and elder abuse

Home is not always a safe place for everyone. The limitations on activities outside the home as a result of the COVID-19 pandemic have unintended, negative consequences for at-risk families. The closure of businesses, churches, schools, and community centers disrupts social support systems, causes job loss and exacerbates economic vulnerability. Experience internationally has shown that family violence (including IPV, child abuse, and elder abuse) can escalate during and after large-scale disasters or crises.[11] Indeed, there has been a surge of domestic violence calls to law enforcement and crisis hotlines. Conversely, there has been a decrease in reports of suspected child and elder abuse to county agencies because of the drastically limited contact these victims have with the outside world.[12] Unfortunately, the trauma of family violence is compounded by the psychological distress caused by the pandemic. Physicians and other health care professionals need to be mindful that the pandemic and public health response to it might result in trauma and re-traumatization for many, especially vulnerable patients.

[9] Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

[10] The Lancet Psychiatry: Patients with mental health disorders in the Covid-19 epidemic, (Yao, Chen, & Xu, 2020), https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30090-0/fulltext

[11] B. Boserup, M. McKenney and A. Elkbuli, Alarming trends in US domestic violence during the COVID-19 pandemic, American Journal of Emergency Medicine (2020), https://doi.org/10.1016/j.ajem.2020.04.077

New Zealand Family Violence Clearinghouse (NZFVC). (2020). Preventing and Responding to Family, Whānau and Sexual Violence during COVID-19. Available at https://nzfvc.org.nz/COVID -19/preventing-responding -violence-COVID -19

World Health Organization: COVID 19 and violence against women: What the health care systems can do, March 26th, 2020

[12] EY Thomas, A Anurudran, K Robb, and TF Burke. Spotlight on child abuse and neglect response in the time of COVID-19. Lancet Public Health. 2020 Jul:5(7):e371. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7326432/

SCREEN

1 Use 2-item KP Social Needs Questionnaire (SNQ-2) to identify urgent needs.

If patient indicates social need

Additional time | No additional time

Also administer KP Social Risk Questionnaire (SRQ-18).

Connect to resources.

2 Administer KP Social Risk Questionnaire for deeper understanding of social context.

If EPIC SDOH functionality is activated in KP HealthConnect

YES | NO

Document results in EPIC SDOH functionality.

Document using a smart data element (SDE).

ⓘ

Special instructions for specific social needs

+ If patient's **food insecurity** is considered health-harming – for example, they're instructed to take medications with food but cannot – develop/activate clinical escalation pathway.
+ If patient indicates **financial strain**, ask follow-up questions to identify what assistance is important. For example, food resources can be shared with patients who cannot afford nutritious meals.

CONNECT TO RESOURCES

1 Use Thrive Local to identify appropriate resources in patients' local communities.

If Thrive Local is not available, then options are:

A Look in Playbook **Resource Section** and provide to patients, as appropriate.

B Call 211 or go to http://211.org/ to identify up-to-date resources in patients' local communities.

Links to resources:
+ Food
+ Housing
+ Homelessness*
+ Social isolation
+ Financial strain
+ Behavioral health
+ Seniors

2 Document resources that were provided to the patient and set date and person to conduct follow up. Use a smart data element (SDE) if not documenting in EPIC SDOH functionality.

ⓘ

*Special instructions for homelessness

+ Upon validating homeless status, discuss temporary isolation procedure with patient.
+ Get patient consent for discharging to temporary isolation space, if clinically indicated.
+ Check regional surge plan for up-to-date info about alternative venues designated for homeless patients.
+ Follow safe transportation protocol.
+ Notify public health department about patient discharge.

FOLLOW UP

Conduct follow up outreach, if appropriate, according to local, regional, and/or national protocols for specific populations.

1 Ask if previously offered resources were used and/or helpful.

2 Ask if patient has new or additional needs. If yes, conduct a full screening if possible (see Screen section).

3 Connect to resources as needed (see Connect to Resources section).

4 Document outcome of follow up. Use a smart data element (SDE) if not documenting in EPIC SDOH module.

Follow up within 1 week:
+ Patients at high risk for medical decompensation due to their social need and/or a high-risk transition. Example: Patient leaving hospital, skilled nursing facility, rehabilitation or home health program, who has limited mobility and is experiencing food insecurity.

Follow up after 1 week or longer:
+ Patients not currently experiencing acute medical symptoms. Follow up as clinically indicated or per existing program follow up protocol. Example: Patient experiencing food insecurity but without any nutrition-related medical conditions and who is self-sufficient and or has caregiver support in following up on resource information.

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Screening for Social Needs

General Screening Guidance

When care teams screen for social factors affecting — or potentially affecting — patients' health, they can provide care that is appropriate for each person's social context. Social risks are defined as "specific adverse social circumstances that are associated with poor health, like social isolation or housing instability."[13] Social needs, on the other hand, depend on people's preferences and priorities, e.g., their readiness to seek support or assistance on a social factor (such as housing or food). An individual may not be fully aware of their current social needs, and those social needs may be more apparent to those around them. Also, an individual may have current needs but may choose not to receive help. Administering a questionnaire can help to uncover social needs and risks that might not be immediately evident but are essential to address when patients are discharged from hospitals or outpatient settings and returned to their homes. Additional screening actions for patients experiencing homelessness, food insecurity, social isolation, and financial strain are listed here separately.

While many patients might have experienced social needs prior to the onset of the COVID-19 global pandemic, others are confronting new challenges that require assistance. Some of the most common factors affecting people during COVID-19 are:

+ Housing insecurity and homelessness

+ Food insecurity

+ Needs associated with prolonged social isolation, especially among seniors, people living alone, and people living in quarantine

+ Financial strain/income loss, including difficulty paying bills and rent/mortgage payments

+ Personal safety issues, including interpersonal violence or abuse

+ Access to childcare for those who are working or otherwise unable to care for their children

+ Employment changes, leading to reduction or loss of income and benefits

ACTION STEPS FOR FRONTLINE CARE TEAM

+ Care team member(s) performing care coordination, care management, or similar functions can administer screening(s). Note: Non-clinical staff can administer.

+ There are 2 tools that have been endorsed for use at Kaiser Permanente, the **KP Social Needs Questionnaire (SNQ-2)** and the **KP Social Risk Questionnaire (SRQ-18).**

  • The 2-item **SNQ-2** is suited for brief encounters.

  • The **SRQ-18** addresses social risks and can be used as time allows to gain a fuller picture of a member's social context. The SRQ-18 covers 7 social risk domains (financial strain, food insecurity, transportation issues, housing instability, social connection, stress, and intimate partner violence).

+ If a patient screens positive for social needs, connect to resources. (See Connect to Resources section.)

+ If a patient screens positive for intimate partner violence during an office or telehealth visit, provide resources if safe (see resources), refer to appropriate services, and discuss follow-up care.

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[13] Alderwick, H., & Gottlieb, L. (2019). Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. The Milbank Quarterly, 97(2), 407–419. https://doi.org/10.1111/1468-0009.12390

Additional action steps: Homelessness

+ If a patient screens positive for homelessness and presents with a cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, or new loss of taste or smell:

    - AND is clinically **unstable**: Consult with Infectious Diseases for COVID-19 testing and follow standard PUI protocol.

    - AND is clinically **stable**:

        o Assess patient and if no clear alternative diagnoses for symptoms, follow protocols for COVID-19 testing.

        o If there are clear alternative diagnoses for symptoms, then follow normal care protocols.

        o If discharge is recommended, clinic manager/nurse/ED care coordinator validates homelessness.

Additional action steps: Food insecurity

If a patient's food insecurity is considered health-harming — for example, they're instructed to take medications with food but cannot — develop/activate clinical escalation pathway.

Additional action steps: Social isolation[14,15]

+ If a patient screens positive for social isolation/loneliness:

    - Conduct additional assessment to further assess the patient's social isolation. Note that known risk factors take into account the physical distancing required by COVID-19. They include:

        o Living alone

        o Living with or caregiver for a person with dementia or memory loss

        o Recently widowed, separated, or divorced

        o Currently in an institutional setting that is not allowing visits from family members/friends

        o Homebound person of any age

        o In clinical isolation or quarantine for COVID-19 symptoms

        o Dependency on others for transportation

        o No internet access at home

        o New mothers with limited social support

Additional action steps: Financial strain

+ If a patient indicates financial strain, ask follow-up questions to identify what specific types of assistance are important. For example, food resources can be shared with patients who cannot afford nutritious meals; financial counseling can be a resource for people dealing with debt.

[14] Holt-Lunstad, J. (2017). The Potential Public Health Relevance of Social Isolation and Loneliness: Prevalence, Epidemiology, and Risk Factors. Public Policy & Aging Report, 27(4), 127–130. https://doi.org/10.1093/ppar/prx030

[15] Samuel, K. (2020, May 6). Never Alone But Always Lonely: The Social Isolation of Being a New Mother. Samuel Centre For Social Connectedness. https://www.socialconnectedness.org/never-alone-but-always-lonely-the-social-isolation-of-being-a-new-mother/

Additional action steps: Intimate partner violence

+ If a patient presents for an in-person office visit, consider the following safety and confidentiality practices:

    • Universal private rooming of patient and avoid screening while others are present, including children older than 3 years of age.

    • Consider an introductory statement to emphasize the confidentiality of the screening process and the health and safety of the patient.

+ Whether screening for intimate partner violence in person or via phone or video, use specific scripting to normalize disclosure. For example:

    • "Especially during this time of COVID, we are asking all of our patients about food, financial stress, housing, and relationship safety. We know many of our patients are experiencing extra stress, and social factors that go unaddressed can shape a person's health."

+ Screen with questions your organization has selected, drawing from validated or tested sources.

+ If there is no disclosure of violence:

    • Provide a supportive response and offer literature (such as a patient brochure or safety card) if they would like to share with a friend.

+ If a patient discloses violence:

    • Assess risks, provide resources, if safe to do so, refer to appropriate health care and community services, and develop a follow-up plan. (See appendix for resources.)

Additional guidance: Telehealth visits[16,17,18]

+ The application of trauma-informed principles to in-person visits and virtual encounters can increase engagement in care and provide opportunities for protective, healing connections.

+ Health care professionals must embrace principles of effective trauma-informed telehealth visits:

    • Safety: Patients might wish to conduct visits from a car, garage, or other private setting. They might also consider the use of headphones or earbuds to ensure privacy. If a patient suddenly looks up or from side to side during a visit, or looks frightened or concerned, ask yes/no questions such as "Do I need to call 911?" "Do we need to disconnect?" "Can I call you back?"

    • Trustworthiness and transparency: Sit far enough from the screen so patients can read your body language and to ensure better eye contact.

    • Collaboration and mutuality: Collaboratively identify and develop an agenda at the beginning of the visit. Notice lag time and wait 3 seconds before responding to avoid rushing patients.

    • Empowerment, voice, and choice: Allow patients to choose where their telehealth visits take place. Do not suggest a bedroom. Emphasize that the topic of discussion can change and visits can end at any time.

    • Cultural, historic, and gender issues: Be sensitive to patients' feelings about revealing personal space. Refrain from comments about their homes. Seek ways to make telehealth accessible to those who lack home access to technology/connectivity.

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[16] Substance Abuse and Mental Health Services Administration. (2014, July). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

[17] Megan Gerber, MD, MPH, FACP COVID-19 Pandemic Trauma Informed Care [PowerPoint Presentation].

[18] Family Violence Prevention Program and Telehealth During the COVID-19 Pandemic, Southern California Kaiser Permanente Webinar. June 11, 2020.

Connect to Resources

Guidance for Connecting People to Community-Based Resources

Linking patients to services to address their social health can contribute to improved health outcomes. Provide information about local community resources to all patients whose screenings indicate they might need help with social factors. Additional actions for patients experiencing homelessness and food insecurity are listed here separately.

ACTION STEPS FOR
FRONTLINE CARE TEAM:
General needs

+ If available, use your organization's social service resource locator to identify appropriate resources in patients' local communities (Learn more about KP's Thrive Local effort here.)

+ If a social service resource locator is NOT available:

  - Use a resource such as a **local 211** to identify current resources in patients' local communities. Go to http://211.org/ to find to a local 211 organization.

  - Also review resources available in this playbook:

    o Housing instability

    o Food insecurity

    o Social isolation

    o Financial strain

    o Seniors

    o Intimate Partner Violence

    o Digital Access

  - As needed, print 1-page **resources list** (in appendix, organized by state) and provide to patients.

+ Document the resources provided to a patient and set date and person to conduct follow up.

> **211 Information and Referral:**
>
> 211 agencies offer information on a wide range of governmental and community-based services, with a current focus on services to meet COVID-19-related needs. They are available in many communities.

> **One-page lists of key resources, by state:**
>
> A static list of state or local services for common social needs, compiled by Kaiser Permanente staff. (See appendix for lists.)

Additional action steps: Homelessness

+ Once homeless status is validated, clinic manager/nurse/ED care coordinator should discuss temporary-isolation procedures and policies with patient.

+ Get patient's consent for discharging to hotels or other temporary isolation spaces, if clinically indicated.

  • Document in health records.

+ Check for available resources:

  • As available, see social service directory, which might include resources such as emergency housing, housing mediation, eviction prevention, and rent/mortgage payment assistance.

+ Make referrals (following organizational process) to connect patients to community-based organizations or local public health agencies to provide temporary isolation spaces (i.e., hotels, RVs) and needed support.

  • Follow standardized protocols for notifying public health departments about patients being discharged into public health temporary quarantine or isolation.

+ Document referrals and notifications in health records.

+ Follow safe transportation protocol.

Additional action steps: Food insecurity

If a patient is part of a specific sub-population, suggest resources (see appendix) as follows:

Sub-population	Suggested resource
Food-insecure homebound seniors	Seek home-delivered meal programs
Food-insecure patients whose caregivers are impacted by COVID-19 and cannot cook or grocery shop	Seek grocery or meal-delivery services. (Could be a paid-for service or help from neighbors or others in a patient's social network.)
Food insecurity related to financial strain (for patients who are not homebound, households that utilize school-based programs, etc.)	Refer to food banks, apply for SNAP, apply for WIC, apply for Pandemic EBT, use school meals sites. (Follow distancing and protection guidelines when seeking in person services.)
Patients discharged after hospitalization for COVID-19	Enroll in medically tailored meals programs, if available. Seek grocery or meal-delivery services. (Could be a paid-for service or help from neighbors or others in a patient's social network.)
Patients who have tested positive for COVID-19 without hospitalization	Seek grocery or meal-delivery services. (Could be a paid-for service or help from neighbors or others in a patient's social network.) For SNAP enrollees, online ordering and curbside pickup is available through Amazon and WalMart using EBT in select states. Patients should check for other retailers that offer this service as well, being mindful of any isolation or quarantine requirements.

Follow Up

Follow-up Guidance

Follow-up outreach to patients with known social needs is recommended to ensure their needs have been met and to identify any new concerns.

+ Where available, use existing follow-up protocols.

+ If existing protocols are not available, identify individuals (e.g., navigators, care coordinators) to do follow-up outreach. If available, a risk score can be used to prioritize patients for follow-up outreach.

+ When determining timeframe for follow up, consider patients' acuity, the nature of their social needs, and availability of resources.

  • Suggested timeframes:
    o Follow up within 1 week:
      – Patients at high risk for medical decompensation due to their social needs and/or a high-risk transition.
      – Example: A patient leaving a hospital, skilled nursing facility, rehabilitation or home-health program who has limited mobility and is experiencing food insecurity.
    o Follow up after 1 week or longer:
      – Patients not currently experiencing acute medical symptoms. Follow up as clinically indicated or per existing protocol.
      – Example: A patient experiencing food insecurity, but without any nutrition-related medical conditions and is self-sufficient or has a caregiver to help follow up on information regarding resources.

ACTION STEPS FOR FRONTLINE CARE TEAM

+ Conduct outreach:
  • Ask if previously offered resources were used and/or helpful.
  • Ask patients if there are new or additional social factors affecting their health. If possible, conduct a full screening. (See Screen/Assess section.)
  • Connect to new/additional resources as needed.(See Connect to Resources section.)

+ Document status/outcome of follow up (i.e., needs met, connected to resources, any additional follow up needed).

Behavioral Health

Behavioral Health Needs During a Disaster

Managing the spectrum of behavioral health needs

The unprecedented circumstances surrounding COVID-19 have created a great deal of stress and uncertainty. Given the nature of the COVID-19 pandemic, there is guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA)[19] to approach this issue from a disaster preparedness lens and to provide guidance and resources accordingly. It is important to note that high-stress situations, such as the current pandemic, can exacerbate symptoms in patients with diagnosed behavioral health conditions; trigger symptoms of behavioral health conditions previously in remission or not previously diagnosed; and present stress reactions that closely mimic a number of behavioral conditions. Therefore, it is helpful to support patients with information and referrals to resources, as needed.

DISASTER BEHAVIORAL HEALTH MANAGEMENT

Per SAMHSA, disaster behavioral health management is the provision of mental health, substance use, and stress management services to disaster survivors and responders.[20] Most people who are coping in the time of a disaster are normal, well-functioning people struggling with the disruption and loss caused by the disaster — in this case, COVID-19. Fear and anxiety about infectious disease can be overwhelming. Patients might present with signs and symptoms of a behavioral health disorder (e.g., excessive worry, changes in sleep and/or eating patterns, etc.) when, in fact, they are experiencing a stress response. Those who are experiencing a stress response do not see themselves as needing behavioral health services and are unlikely to request them. People impacted by disaster often find terms like "assistance with resources" and "talking about disaster stress" to be acceptable, and services described as "mental health services" to be for someone else. Consider these points when discussing such concerns with patients and their support systems.

KEY CONCEPTS AND CONSIDERATIONS

+ There are 2 types of disaster trauma: individual and community.

+ Disaster behavioral health assistance is often more practical than psychological.

+ Disaster behavioral health services must be uniquely tailored to the communities they serve.

+ Survivors respond to active, genuine interest, and concern.

+ Health care providers might need to set aside traditional methods, avoid using mental health labels, and use an active outreach approach to intervene successfully.

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[19] SAMHSA - Substance Abuse and Mental Health Services Administration. (2021). https://www.samhsa.gov/

[20] Substance Abuse Delivering Behavioral Health Services After a Disaster. (2017, January 20). SAMHSA - Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/health-services-after-disaster

Screen/Assess

Based on a review of recommendations from both SAMHSA and the Centers for Disease Control and Prevention (CDC), Kaiser Permanente has developed operational guidance for supporting vulnerable populations with existing or emerging behavioral health needs.

OVERALL GUIDANCE

Target population for screening should be PUI and patients with confirmed cases of COVID-19 who have apparent disaster behavioral health needs.

+ Patients with known behavioral health conditions should continue their treatments whenever possible:

  • Follow local workflows to connect patients back to their treating providers of record.

  • If patients do not believe continuity is possible, see section on Connecting to Resources for guidance on making those connections. Additionally, these patients should be monitored for worsening symptoms, including suicidality and/or other signs of decompensation.

  • Mood disorders are likely to be exacerbated due to the psychological distress related to COVID-19. As such, we recommend that screening is focused on patients' functioning and ability to seek help, particularly from their social support networks.

+ For patients with behavioral health conditions previously in remission or not previously diagnosed:

  • Normalize offers of assistance by using statements such as, "During a time like this, getting support can be beneficial."

  • Connect patients who mention having historical therapeutic relationships to resources.

  • Suggest patients seek help finding positive ways to cope with the stress of the pandemic.

+ For patients having common stress reactions (i.e., symptoms lasting fewer than 4 weeks or began at the onset of the pandemic; have no significant functional impairments; and report no history of behavioral health conditions or symptoms prior to the onset of COVID-19):

  • Normalize patients' experiences of worry, agitation, low mood, disturbances in sleep and appetite.

  • Encourage patients to communicate their ongoing experiences to health care professionals and/or their social support networks.

  • Encourage patients to identify their strengths and what has worked for them in the past when dealing with extreme stress.

  • Offer to help them speak to someone during this high-stress period. See section on Connecting to Resources.

ACTION STEPS FOR FRONTLINE CARE TEAM

+ For patients with active behavioral health conditions:

  • Work with the patient on plans to reduce stress and maintain healthy behaviors and positive coping skills.

  • Recommend regular clinical contact when possible with the provider of record.

  • Encourage participation in virtual and online forums. (See section on Connecting to Resources.)

  • Ensure adequate medication supply for the patient.

  • Discuss/reinforce the importance of medication adherence and adequate access to services.

- Encourage the patient to adopt a schedule or routine (e.g., getting out of bed at the same time of day, scheduling virtual or telephone social contact, exercise) to prevent symptoms from worsening.

+ For patients newly presenting with behavioral health concerns:

  - Assess to determine if they are at risk for suicidality or harming themselves.

  - In-depth screening tools commonly used in clinical practice (e.g., PHQ-2/9, GAD-2/7, PTSD screening tools) might be of limited usefulness because patients are likely to be highly agitated due to the elevated psychological distress most people experience during a disaster.

  - Assess patients' daily functioning and ability to seek help.

  - Review with patients their strengths and what has worked well for them in the past when dealing with extreme stress.

  - Normalize their experiences by emphasizing that distress in the face of this pandemic is common and experienced by the majority. Potential questions to ask include:

    o *Because of COVID-19 and the national emergency, are you experiencing anxiety, stress, depression, and/or general mental distress?*

    o *Because of COVID-19 and the national emergency, do you feel unsafe in your daily life or are you concerned about the safety of one of your children or a child you live with?*

    o *Would it be helpful to talk to someone about your concerns with COVID-19?*

  - If patients answer yes to any of the above 3 questions, hand them off to a behavioral health professional or care-coordinator, as appropriate and consistent with local policies.

+ For patients assessed to have a functional impairment or suicidality risk, follow standard workflow for follow up:

  - Ensure a warm handoff, whenever possible, to a care team member responsible for following up after screenings. This role could include a behavioral health consultant, behavioral health care coordinator, nurse care manager, or social worker.

  - Document conversations with patients and their responses in their health records.

+ As appropriate, provide patients information about using digital resources and tools to connect with others during social distancing. (See section on Connecting to Resources.)

Connect to Resources

+ **There may be several resources available to help people manage the situational stressors related to COVID-19, including behavioral health and wellness services and connecting with a primary care provider or behavioral health provider.**

+ **Public resources, including virtual support groups or a staffed hotline.**

REFERRALS TO SPECIALTY SERVICES

To connect eligible patients to specialty services for behavioral health concerns, please refer to established referral protocols.

NATIONAL AND LOCAL RESOURCES

National hotlines:

+ Disaster Distress Helpline (24/7)
  1-800-985-5990 TTY 1-800-846-8517

+ Suicide Prevention Lifeline (24/7)
  1-800-273-8255 TTY 800-799-4889

+ Spanish Suicide Prevention Line (24/7)
  1-888-628-9454

+ Eldercare Locator 1-800-677-1116 —
  services for older adults and their families

+ Substance Abuse and Mental Health Services Administration's (SAMHSA) National Helpline (24/7) 1-800-662-4357

+ National Domestic Violence Hotline
  1-800-799-7233 older adults and their families

+ Substance Abuse and Mental Health Services Administration's (SAMHSA) National Helpline (24/7) 1-800-662-4357

+ National Domestic Violence Hotline
  1-800-799-7233

Local hotlines:

	State	Local Resource Help or Hotline	Resources
1	**California**	Organized at the County-Level, Each County Has Crisis Line	http://www.suicide.org/hotlines/california-suicide-hotlines.html
2	**Colorado**	Crisis Hotline at **884-493-TALK** or Text **TALK to 38255**	https://coloradocrisisservices.org/
3	**Georgia**	Crisis Hotline at **800-715-4225**	https://namiga.org/crisis-info/
4	**Hawaii**	Crisis Hotline for Oahu **808-832-3100** and Other Islands **800-753-6879**	http://www.suicide.org/hotlines/hawaii-suicide-hotlines.html
5	**Maryland**	Maryland **211** Option 1	https://health.maryland.gov/suicideprevention/Pages/Maryland-Crisis-Hotline.aspx
6	**Oregon**	Organized at the County-Level, Each County Has Crisis Line	https://www.oregon.gov/oha/ph/PreventionWellness/SafeLiving/SuicidePrevention/Pages/crisislines.aspx
7	**Virginia**	National Crisis Hotline at **800-273-8255**	http://www.vdh.virginia.gov/suicide-prevention/
8	**Washington**	Crisis Hotline at **866-789-1511**	https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines
9	**Washington DC**	Crisis Hotline at **888-793-4357**	https://dbh.dc.gov/service/access-helpline

PUBLIC, FREE VIRTUAL RESOURCES

An important aspect of coping with pandemic-related stress and managing a behavioral health condition is receiving ongoing social support. Support groups frequently play a pivotal role in managing not only stress, but symptoms that come from having a behavioral health condition. Readily available, public, free, support resources are on the internet through different platforms, such as Zoom and Facebook. Below are a few resources available to patients with the most common behavioral health conditions:

+ AA meetings: https://www.aa.org/pages/en_US/options-for-meeting-online

+ Anxiety and depression support groups: https://adaa.org/adaa-online-support-group

+ Support groups for varied concerns: https://www.supportgroupscentral.com/index.cfm#anc1

+ Mental Health America Support Groups: https://www.inspire.com/groups/mental-health-america/

+ National Alliance for Mental Illness (NAMI) family support: https://www.nami.org/Find-Support

Follow up

Given the rapidly changing medical and social context of the COVID-19 pandemic and the intense demand on community services, following up with patients helps ensure their needs are resolved and any new concerns get addressed.

OVERALL GUIDANCE

Conduct outreach to patients who are known to have ongoing behavioral health concerns to confirm that their needs have been met and to identify any new concerns.

+ Identify appropriate individuals to do outreach/follow-up.

+ The frequency of follow-up will be determined by the nature of the need, a patient's motivation and problem-solving capacity, the extent of his or her social network, and the availability of community resources.

ACTION STEPS FOR FRONTLINE CARE TEAM

Conduct outreach:

+ Ask if previously offered resources were used and helpful.

+ Ask if the patient has new or additional needs. If possible, conduct a full screening. (See Screen/Assess section.)

+ Connect to new/additional resources as needed. (See Connect to Resources section.)

+ Document status/outcome of follow-up.

Appendices

Screen/Assess

General Social Needs Screening Tools

TWO ITEM SOCIAL NEEDS QUESTIONNAIRE (SNQ-2) USED BY KAISER PERMANENTE

1 Do you need help with any of the following at this time? *(Select ALL that apply)*

☐ Food

☐ Housing

☐ Utilities

☐ Finances

☐ Transportation

☐ Loneliness or social isolation

☐ Personal safety

☐ Employment

☐ Childcare

☐ Other

☐ I don't need help with any of these

2 Which of your needs are urgent? *(Select ALL that apply)*

☐ Food

☐ Housing

☐ Utilities

☐ Finances

☐ Transportation

☐ Loneliness or social isolation

☐ Personal safety

☐ Employment

☐ Childcare

☐ Other

☐ None of my needs are urgent

Social Isolation: Considerations for assessment[21]

According to a 2020 Kaiser Permanente social needs survey, social isolation is the second most prevalent social factor our members need help with. Social isolation or loneliness can be serious health issues and are proven risk factors for premature mortality, as dangerous as heavy smoking, obesity, and lack of physical activity. During "stay-at-home" periods due to the global pandemic, a person who lives alone and is having little or no regular contact with family, friends, or caregivers would be considered severely socially isolated, especially if he or she is not an active user of digital technology. This socially isolated person might feel their social isolation more than someone who lives alone, but routinely conducts uses technology to connect with others. In other words, social isolation has both structural and emotional dimensions. A person in clinical isolation or quarantine for COVID-19 symptoms might feel the impact of social isolation more acutely.

Social Isolation: Definitions and risk factors

Social isolation is an objective state measured by the number and/or frequency of social contacts and nature of the contacts.

Loneliness is an unpleasant, subjective state of sensing a discrepancy between the desired amount of companionship or emotional support and that which is available in the person's environment. Loneliness has both an emotional and social dimension.

+ **Emotional loneliness** is the feeling that results when someone feels the lack of a reciprocated intimate relationship with someone they care about and want to feel cares about them.

+ **Social loneliness** is a feeling that results when someone is missing engagement with a wider social network, akin to the emotional dimension of social isolation. This feeling is particularly likely to arise during this COVID-19 crisis because people cannot engage in their usual social activities.

People can feel socially isolated or lonely even if they are surrounded by or are in frequent contact with other people, depending on how they are

psychologically framing their situations. If they don't feel socially connected to these people or feel that these people don't care about them, they can feel isolated in place. If they miss contact with friends or family, they can feel lonely. On the other hand, distancing can lead to sustained crowding and social tension within households, leading to other concerns such as intimate partner violence and child abuse.

Risk factors for social isolation include:[22,23]

+ Living alone

+ Living with or caring for a partner who has dementia or memory loss

+ Recently widowed, separated, or divorced

+ Homebound person of any age

+ Currently in an institutional setting that is not allowing visits from family members/friends

+ In clinical isolation or quarantine for COVID-19 symptoms

+ Dependency on others for transportation

+ No internet access at home

+ New mothers with limited social support

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[21] Cotterell, N., Buffel, T., & Phillipson, C. (2018). Preventing social isolation in older people. Maturitas, 113, 80–84. https://pubmed.ncbi.nlm.nih.gov/29903652/ and Perlman, D.H., Ph., D., & Peplau, L.A. (2009). Chapter 2 Loneliness Research: A Survey of Empirical Findings.https://pdfs.semanticscholar.org/52b8/89ecaeccab4de5f9aaff4a6d53129895aa7d.pdf

[22] Holt-Lunstad, J. (2017). The Potential Public Health Relevance of Social Isolation and Loneliness: Prevalence, Epidemiology, and Risk Factors. Public Policy & Aging Report, 27(4), 127–130. https://doi.org/10.1093/ppar/prx030

[23] Never Alone But Always Lonely: The Social Isolation of Being a New Mother. (2020, May 06), https://www.socialconnectedness.org/never-alone-but-always-lonely-the-social-isolation-of-being-a-new-mother/

Social Isolation: Assessment

For patients who screen positive for social isolation and loneliness, use one or more of the below sample conversational "check-in" questions to assess whether they are having difficulties related to social isolation/loneliness. These questions are not necessarily stand-alone and can be incorporated into a broader social health check-in.

+ Are you able to achieve a desired amount of social connection with family and friends?

+ Are the "stay-at-home" and physical distancing requirements impacting your social connections with family, friends, and others in your community?

+ Are you experiencing feelings of anxiety, stress, low spirits, or loneliness that are affecting your ability to cope with the current situation? (Use local protocols for assessing/managing routine anxiety and depressive disorders.)

+ How frequently are you engaging with other people outside your home by phone, letter writing, chatting with a neighbor, or video chat services like FaceTime or Zoom?

+ Have you been able to get the food and other necessities or help you need?

+ Do you have someone living with you or nearby who you would feel comfortable asking for help with shopping or other necessities, or for advice and emotional support if you need it?

+ When you are feeling really low, can you find someone you trust to talk to? Who is that person in your life?

+ Do you have Wi-Fi or other internet access where you live and the ability to go online?

+ Are you going outside at least once a day, even onto a balcony or porch, to get some fresh air?

ACTION STEPS FOR FRONTLINE CARE TEAM

+ Conduct conversations with patients using one or more of the above questions to pinpoint areas for additional probing. Use interpreter services where appropriate.

+ If patients indicate they want to talk with a mental health professional, conduct appropriate follow-up.

+ If a patient sounds or appears particularly withdrawn, down, or abnormally somber, refer to the Behavioral Health section of this playbook on screening and assessment. Isolation and loss (particularly among older adults) put individuals at higher risk for suicide.

+ As appropriate, make one or more of the following suggestions to people who do not seem to require referral to a mental health professional:

  • People having difficulty coping with the current situation and are not going outside their living quarters can be encouraged to do so.

  • People who are feeling lonely or cut off from others can be encouraged to set up routine voice (phone) and video chat sessions with family and friends.

  • People who are constantly watching the news should be encouraged to engage in other activities they find enjoyable.

Connect to Resources

General resources

BY-STATE LISTINGS OF RESOURCES FOR COMMON COVID-19 RELATED NEEDS

These lists were compiled in November 2020 for use by Kaiser Permanente staff. These can be adapted for other geographies and provided as handouts to patients.

Resources in Times of Need
CALIFORNIA

Resources in California that can help you get connected to tangible support:

Food Assistance

**CalFresh
(Online SNAP Enrollment)**

https://www.getcalfresh.org/

866- 613-3777

**Centauri Health Systems
(Phone SNAP Enrollment)**

877-282-8335

**California Association
of Food Banks**

https://cafoodbanks.org/find-food-bank

**Women, Children
& Infants Program**

https://www.phfewic.org/how-wic-works/apply-for-wic/

800-852-5770

Financial Resources

Apply for Unemployment

https://www.edd.ca.gov/unemployment/

866-333-4606

Cash Assistance: CalWorks

https://www.cdss.ca.gov/calworks

Apply for Public Assistance

https://www.cdss.ca.gov/benefits-services

Housing

US Dept. Housing and Urban Development (HUD)

https://www.hud.gov/states/california/renting

800-CALL-FHA

Utilities and Mobile Resources

Low-Cost Internet/Computer Access

http://broadband.unitedwaysca.org/

Interpersonal Violence

**National Domestic
Violence Hotline**

800-799-7233 or 800-799-SAFE

**CA Partnership to
End Domestic Violence**

https://www.cpedv.org/domestic-violence-organizations-california

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs / YWCAs

https://www.ymca.net/find-your-y/ and *https://www.ywca.org/*

**CA Child Care Resource
& Referral Network**

https://rrnetwork.org/family-services/find-child-care

Other Resources

Resource Covid-19 CA Response

*Covid-19 CA Response
https://covid19.ca.gov/*

How to apply for coverage

www.kp.org/medi-cal
www.CoveredCA.com
https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

Mental Health

https://findyourwords.org/

California 211

https://www.211ca.org/ or *Dial 211*

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Resource for Californians impacted by job loss

https://onwardca.org/

KAISER PERMANENTE.

Resources in Colorado that can help you get connected to tangible support:

Food

Hunger Free Colorado

https://www.hungerfreecolorado.org/

PEAK (Online SNAP Enrollment)

https://coloradopeak.secure.force.com/

Centauri Health System (Phone SNAP Enrollment)

877-282-8335

CO Dept of Human Services

https://www.colorado.gov/pacific/cdhs/supplemental-nutrition-assistance-program-snap

Feeding America Foodbank locator

https://www.feedingamerica.org/find-your-local-foodbank

Women, Infant, and Children (WIC)

https://www.coloradowic.gov/

WIC toll free 800-688-7777

(se habla español)

Financial Resources

Apply for Unemployment

https://www.colorado.gov/pacific/cdle/unemployment

Apply for Public Assistance

https://www.colorado.gov/pacific/cdhs/benefits-assistance

Housing

Housing Help

https://cdola.colorado.gov/housing-covid19

Utilities Resources

CO Low Income Home Energy Assistance Program

https://www.benefits.gov/benefit/1541

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

Violence Free Colorado

https://www.violencefreecolorado.org/

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and https://www.ywca.org/

Colorado Shines

https://www.coloradoshines.com/

Other Resources

How to apply for coverage

www.kp.org/medicaid/co

www.ConnectforHealthCO.com

https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

Mental Health

https://findyourwords.org/

211 Resource Locator

https://www.211colorado.org/ or Dial 211

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Resources in Times of Need
GEORGIA

Resources in Georgia that can help you get connected to tangible support:

Food

GA Dept of Human Services

https://dfcs.georgia.gov/food-stamps

877-423-4746

Wholesome Wave Georgia (SNAP Enrollment)

https://www.wholesomewavegeorgia.org/snap-enrollment *or 678-631-7101*

Georgia Food Bank Association

https://georgiafoodbankassociation.org/find-your-food-bank/

or 404-419-1738

Atlanta Community Food Bank

https://acfb.org/ or

404-892-9822 text "FINDFOOD"

or "COMIDA" to 888-976-2232

Women, Infant, and Children (WIC)

https://dph.georgia.gov/WIC

800-228-9173

Financial Resources

GA Dept of Labor & Unemployment Compensation

https://dol.georgia.gov/file-unemployment-insurance-claim

Apply for Public Assistance

https://dhs.georgia.gov/public-assistance

Housing

HUD.gov/ Georgia

https://www.hud.gov/states/georgia/renting

Atlanta Housing Authority

https://www.atlantahousing.org/covid19/

HOPE Atlanta

https://hopeatlanta.org/

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

Georgia Coalition Against Domestic Violence

https://gcadv.org/

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and https://www.ywca.org/

Georgia Dept of Early Care and Learning

http://www.qualityrated.org/

Other Resources

How to apply for coverage

www.kp.org/medicaid/ga

www.HealthCare.gov

https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

Mental Health

Website: https://findyourwords.org/

Website: https://chris180.org/

211 Resource Locator

http://211.org/ or Dial 211

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Utilities Resources

Georgia Power

https://www.georgiapower.com/covid-19.html

Georgia Public Service Commission

http://www.psc.state.ga.us/consumer_corner/cc_advisory/payassist.asp

Resources in Times of Need
HAWAII

Resources in Hawaii that can help you get connected to tangible support:

Food

Supplemental Nutritional Assistance Program (SNAP)

https://pais-benefits.dhs.hawaii.gov/

Hawaii Food Bank

http://www.hawaiifoodbank.org/covid-19

800-836-3600

Women, Infant, and Children (WIC)

https://health.hawaii.gov/wic/

808-622-6458

Financial Resources

Apply for Unemployment

https://labor.hawaii.gov/ui/

Temporary Assistance for Needy Families (TANF)

https://humanservices.hawaii.gov/bessd/tanf/

Apply for Public Assistance

https://humanservices.hawaii.gov/

Housing

Office of Housing & Community Development

https://www.hawaiicounty.gov/departments/office-of-housing

808-961-8379

Utilities and Mobile Resources

Low-Income Home Energy Assistance Program (LIHEAP)

https://humanservices.hawaii.gov/wp-content/uploads/2019/09/LIHEAP-Flyer-2020.pdf

Dept of Consumer Affairs - Consumer Advocacy – Public Utilities

https://cca.hawaii.gov/dca/telecommunications/lifeline/

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

HI Domestic Violence Action Center

https://domesticviolenceactioncenter.org/

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and https://www.ywca.org/

PATCH Hawaii

https://www.patchhawaii.org/find-child-care/

Other Resources

How to apply for coverage

www.kp.org/medicaid/hi

https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

State of Hawaii, Department of Health Updates

https://health.hawaii.gov/news/covid-19-updates/

Mental Health

https://findyourwords.org/

Hawaii 211

https://www.auw211.org/

Phone: Dial 211

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Resources in Times of Need
MARYLAND

Resources in Maryland that can help you get connected to tangible support:

Food

SNAP Information

http://dhs.maryland.gov/food-supplement-program/

800-332-6347

Maryland Hunger Solutions (SNAP Enrollment)

https://www.mdhungersolutions.org/get-help/apply-for-snap/

866-821-5552

Maryland Food Bank

https://mdfoodbank.org/

Women, Infant, and Children (WIC)

https://phpa.health.maryland.gov/wic/Pages/Home.aspx

800-242-4942

Financial Resources

Apply for Unemployment

https://dbm.maryland.gov/employees/Pages/DisApplyforUnemploymentBenefits.aspx

Temporary Assistance for Needy Families (TANF)

http://dhs.maryland.gov/weathering-tough-times/temporary-cash-assistance/

800-332-6347

Apply for Public Assistance

https://www.maryland.gov/pages/residents.aspx?view=Assistance%20Programs

Housing

Maryland Department of Housing

https://www.hud.gov/states/maryland/renting

Utilities Resources

Office of Home Energy Programs

http://dhs.maryland.gov/office-of-home-energy-programs/

Maryland Energy Administration

https://news.maryland.gov/mea/2020/03/23/maryland-power-utilities-respond-to-covid-19/

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

Maryland Network Against Domestic Violence

https://mnadv.org/find-help/

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and *https://www.ywca.org/*

MD Child Care and Referral Network

http://www.marylandfamilynetwork.org/MCCRN

Other Resources

How to apply for coverage

www.kp.org/medicaid/md
www.MarylandHealthConnection.gov
https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

State of Maryland, Department of Health Updates

https://coronavirus.maryland.gov/

Mental Health

https://findyourwords.org/

Maryland 211

https://211md.org/ or *Dial 211*

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Resources in Times of Need
OREGON

Resources in Oregon that can help you get connected to tangible support:

Food Assistance

Oregon SNAP Program

https://www.oregon.gov/DHS/ASSISTANCE/FOOD-BENEFITS/pages/index.aspx

Oregon Food Bank

https://www.oregonfoodbank.org/

Partners for a Hunger Free Oregon

https://oregonhunger.org

Women, Infants, and Children (WIC)

https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WIC/Pages/Index.aspx

Financial Resources

Apply for Unemployment

https://www.oregon.gov/employ/unemployment/

Apply for Public Assistance

https://www.oregon.gov/DHS/assistance/

Housing

Oregon Housing and Community Services

https://www.oregon.gov/ohcs/Pages/housing-assistance-in-oregon.aspx

Utilities Resources

Oregon Low Income Home Energy Assistance Program (LIHEAP)

https://www.benefits.gov/benefit/1571

Oregon Energy Fund

https://www.oregonenergyfund.org/energy-assistance/

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

Oregon Coalition Against Domestic and Sexual Violence

https://www.ocadsv.org/find-help

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and *https://www.ywca.org/*

Find Childcare Oregon

http://triwou.org/projects/fcco

Other Resources

How to apply for coverage

www.kp.org/medicaid/or
www.OregonHealthCare.gov
https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

Mental Health

https://findyourwords.org/

Oregon 211

http://211.org/
Phone: Dial 211

American Job Centers

https://www.dol.gov/general/topic/training/onestop

Resources in Times of Need
VIRGINIA

Resources in Virginia that can help you get connected to tangible support:

Food

Virginia Dept of Social Services

https://commonhelp.virginia.gov/access/

800-552-3431 (SNAP Hotline)

Virginia Hunger Solutions

http://vahungersolutions.org

Virginia Food Bank Locator

www.vafoodbanks.org/covid-19-response/

Women, Infants, and Children (WIC)

http://www.vdh.virginia.gov/wic/about/

888-942-3663

Financial Resources

Virginia Employment Commission

www.vec.virginia.gov

866-832-2363

Virginia Dept of Social Services Temporary Assistance for Needy Families

https://www.dss.virginia.gov/benefit/tanf/

804-726-7000

Apply for Public Assistance at Common Help

commonhelp.virginia.gov

Housing

Virginia Housing Development Authority

https://www.vhda.com/about/Pages/VH-COVID19.aspx or 877 -843-2123

Utilities Resources

Virginia Department of Social Services

https://www.dss.virginia.gov/benefit/ea/

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

Virginia Sexual and Domestic Violence Action Alliance

http://www.vsdvalliance.org/#/resources-helpayuda

Childcare

National database of resources in local communities

https://www.childcareaware.org/resources/ccrr-search-form/

School-age programs at local YMCAs & YWCAs

https://www.ymca.net/find-your-y/ and *https://www.ywca.org/*

Childcare Aware of Virginia

https://vachildcare.com/

Other Resources

Additional Resources Virginia

https://www.virginia.gov/coronavirus-updates/

How to apply for coverage

www.kp.org/medicaid/va

www.HealthCare.gov

https://continuecoverage.kaiserpermanente.org/losing-job-coverage/

Mental Health

https://findyourwords.org/

Virginia Easy Access

Special resources for seniors and people with disabilities.
Website: easyaccess.virginia.gov

Virginia 211

https://www.211virginia.org/

or Dial 211

American Job Centers

https://www.dol.gov/general/topic/training/onestop

WASHINGTON

Resources in Washington that can help you get connected to tangible support:

Food Assistance

Basic Food Benefits

> *https://www.dshs.wa.gov/esa/community-services-offices/basic-food*

Pregnant Women and Other Services

> *https://www.washingtonconnection.org/home/*

Washington Food Pantries

> *https://foodlifeline.org/need-food/*

Financial Resources

Apply for Unemployment

> *https://esd.wa.gov/unemployment*

Apply for Public Assistance

> *https://www.dshs.wa.gov/food-cash-medical*

Housing

Washington State Department of Social and Health Services

> *https://www.dshs.wa.gov/housing-assistance*

Utilities and Mobile Resources

Washington State Low Income Home Energy Assistance Program (LIHEAP)

> *https://www.commerce.wa.gov/growing-the-economy/energy/low-income-home-energy-assistance/*

Interpersonal Violence

National Domestic Violence Hotline

> *800-799-7233 or 800-799-SAFE*

WA State Coalition Against Domestic Violence

> *https://wscadv.org/get-help-now/*

Childcare

National database of resources in local communities

> *https://www.childcareaware.org/resources/ccrr-search-form/*

School-age programs at local YMCAs / YWCAs

> *https://www.ymca.net/find-your-y/* and *https://www.ywca.org/*

Child Care Aware of Washington

> *https://childcareawarewa.org/*

Other Resources

How to apply for coverage

> *www.kp.org/Medicaid/wa*
>
> *www.wahbexchange.org*
>
> *https://continuecoverage.kaiserpermanente.org/losing-job-coverage/*

Mental Health

> *Website: https://findyourwords.org/*

Washington State 211

> *https://wa211.org/*
>
> *Phone: Dial 211*

American Job Centers

> *https://www.dol.gov/general/topic/training/onestop*

General WA resource for COVID-19

> *https://covid19helpwa.org/?fbclid=IwAR3GWfgzhXYmZWPEG8sDRX1oYYdgPUk7i40dO9Edj3DmcS5lrbJ8Wpq5Es&mc_cid=dc60011e0a&mc_eid=44d2f8bd89*

Resources in Times of Need
WASHINGTON, DC

Resources in Washington, DC that can help you get connected to tangible support:

Food

Commodity Supplemental Food Program (CSFP)

https://www.capitalareafoodbank.org/ what-we-do/direct-food-distribution- programs/commodity-supplemental- food-program/

202-644-9880

DC Department of Human Services

https://dhs.dc.gov/service/snap-eligibility

DC Hunger Solutions

https://www.dchunger.org

Capital Area Food Bank

https://www.capitalareafoodbank.org/f ind-food-assistance/

202-644-9807

Women, Infant and Children (WIC)

https://dchealth.dc.gov/node/125192

202-442-9397

Financial Resources

Apply for Unemployment Compensation

https://does.dc.gov/service/start-your- unemployment-compensation- process

202-724-7000

Housing

DC Housing Authority

https://webserver1.dchousing.org/?pa ge_id=284

Utilities and Mobile Resources

District of Columbia Public Service Commission

https://dcpsc.org/Coronavirus.aspx

202-626-5120

Combined Application

Apply for one or more programs

+ *Temporary Assistance for Needy Families (TANF, financial assistance)*
+ *Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps)*
+ *Medical Assistance (Medicaid, Alliance and other medical assistance programs)*

https://dhs.dc.gov/service/apply-benefits

202-727-5355

Interpersonal Violence

National Domestic Violence Hotline

800-799-7233 or 800-799-SAFE

DC Coalition Against Domestic Violence

https://dccadv.org/resources/get- help/

Childcare

National database of resources in local communities

https://www.childcareaware.org/reso urces/ccrr-search-form/

School-age programs at local YMCAs and YWCAs

https://www.ymca.net/find-your-y/ and *https://www.ywca.org/*

My Child Care DC

http://childcareconnections.osse.dc.g ov/

Pepco

Low-Income Discount Programs & Seniors and Disabled

https://dcpsc.org/Consumers- Corner/Programs/Low-Income- Discount-Program.aspx or 202-496- 5830

Other Resources

Mayor Bowser of the District of Columbia

https://coronavirus.dc.gov/

Mental Health

https://findyourwords.org/

211 Resource Line

http://211.org/ or *Dial 211*

American Job Centers

https://www.dol.gov/general/topic/trai ning/onestop

Housing instability resources

Due to COVID-19, many people have lost jobs and income, and these economic factors will likely impact their housing-related needs. In many communities, there are programs that provide emergency financial assistance and address basic housing needs, such as paying for rent and utilities. These programs might be offered by a variety of local nonprofit or faith-based organizations and government agencies.

KEY RESOURCES INCLUDE:

+ **Legal Services and Housing Assistance:** Local organizations in each state that offer support with legal services, housing assistance, tenant rights, education and advocacy.
https://justshelter.org/community-resources/

+ **National Low-Income Housing Coalition:** Has a searchable database and map of multifamily properties that are covered under federal moratoriums on evictions. Renters and their allies can use these tools to know if they are protected.
https://nlihc.org/federal-moratoriums?ct=t%28update_041720%29

+ **Community Action Agencies:** Local community action agencies may offer assistance with housing costs and other support.
https://communityactionpartnership.com/find-a-cap/

+ **United Way:** Local United Ways are useful resources for identifying local organizations providing aid during the pandemic.
https://www.unitedway.org/

+ **Long-term Affordable Housing:** Local public housing authorities and other public agencies provide subsidized apartment and rent subsidy programs for qualifying individuals.
https://www.hud.gov/program_offices/public_indian_housing/pha/contacts. Note that many programs have long waiting lists, and housing agencies may have limited staff available during this time.

The U.S. Department of Housing and Urban Development (HUD) rental assistance resource directory can be found at:
https://www.hud.gov/topics/rental_assistance/local

+ **HUD State Rental Resource Directory**: On each of the state pages, there is a heading titled "I WANT TO," which contains additional resources and information related to housing insecurity and homelessness.

State	Resources
California	https://www.hud.gov/states/california
Colorado	https://www.hud.gov/states/colorado
Georgia	https://www.hud.gov/states/georgia
Hawaii	https://www.hud.gov/states/hawaii
Maryland	https://www.hud.gov/states/maryland
Oregon	https://www.hud.gov/states/oregon
Virginia	https://www.hud.gov/states/virginia
Washington	https://www.hud.gov/states/washington
Washington D.C.	https://www.hud.com/hud-homes/washington-dc

+ **National Health Care for the Homeless Council:** Local Health Care for the Homeless programs provide a starting point for finding health care resources for people experiencing homelessness. Local programs will have information related to what community resources are available and how to make referrals for patients to access these resources.

The local program directory can be found here: *https://nhchc.org/directory/*

Food insecurity resources

KEY RESOURCES INCLUDE:

+ **Supplemental Nutrition Assistance Program (SNAP):** SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency. To get SNAP benefits, people must apply in the state where they currently live and must meet certain requirements, including resource and income limits. Note that there might be a substantial wait for benefits to be approved, so additional short-term measures to address food insecurity might be necessary. Programs by state are available in the appendix.

+ **Coronavirus Pandemic EBT (P-EBT):** States can provide nutrition assistance (on EBT cards) to families whose children would receive free or reduced-price meals if not for school closures caused by pandemic. Enrollment processes and benefit amounts vary by state. Students can receive if undocumented.

+ **Food banks:** Feeding America food bank network makes food available to anyone who needs it without obligation, regardless of circumstances, and is free and confidential.
  https://www.feedingamerica.org/find-your-local-foodbank

+ **The Special Supplemental Nutrition Program for Women, Infants and Children (WIC):** WIC provides food, health care referrals and nutrition education for eligible pregnant, breastfeeding and non-breastfeeding postpartum women, and for as well as infants and children up to age five. Note, there might be a substantial wait for benefits to be approved, so additional short-term measures to address food insecurity might be necessary.
  https://www.fns.usda.gov/wic

+ **School Meals for Kids with School Closures:** Parents, guardians and caretakers are able to pick-up nutritious meals for children ages 0-18 at no cost while schools are closed due to COVID-19 **USDA Meals for Kids Site Finder** offers directions to nearby sites, hours of operations and contact information across states.
  https://www.fns.usda.gov/meals4kids

Resources by State

State	SNAP	Food Banks	Other
California	**CalFresh** https://www.getcalfresh.org/ **Centauri Health Systems** Phone: 877-282-8335	**California Association of Food Banks** http://cafoodbanks.org/find-food-bank	**Women, Children & Infants Program** https://www.phfewic.org/how-wic-works/apply-for-wic/ Phone: 800-852-5770
Colorado	**PEAK (Online SNAP Application Portal)** https://coloradopeak.secure.force.com/ **CO Dept of Human Services** https://www.colorado.gov/pacific/cdhs/supplemental-nutrition-assistance-program-snap **Centauri Health Systems** Phone: 877-282-8335	**Feeding America Foodbank locator** https://www.feedingamerica.org/find-your-local-foodbank	**Hunger Free Colorado** https://www.hungerfreecolorado.org/ *Note: Hunger Free Colorado can help with SNAP enrollment and locating food banks* **CO Women, Children & Infants Program** https://www.coloradowic.gov/ Phone: 800-688-7777
Georgia	**Wholesome Wave Georgia** https://www.wholesomewavegeorgia.org/snap-enrollment Phone: 678-631-7101 **GA Dept of Human Services** https://dfcs.georgia.gov/food-stamps Phone: 877-423-4746	**Georgia Food Bank Association** https://georgiafoodbankassociation.org/find-your-food-bank/ Phone: 404-419-1738 **Atlanta Community Food Bank** https://acfb.org/ Phone: 404-892-9822 text "FINDFOOD" or "COMIDA" to 888-976-2232	**GA Women, Children & Infants Program** https://dph.georgia.gov/WIC Phone: 800-228-9173
Hawaii	**Department of Health Services** https://pais-benefits.dhs.hawaii.gov/	**Hawaii Food Bank** http://www.hawaiifoodbank.org/covid-19 Phone: 800-836-3600	**HI Women, Children & Infants Program** https://health.hawaii.gov/wic/ Phone: 808-622-6458
Maryland	**Department of Health Services** http://dhs.maryland.gov/food-supplement-program/ Phone: 800-332-6347 **Maryland Hunger Solutions** https://www.mdhungersolutions.org/get-help/apply-for-snap/ Phone: 866-821-5552	**Maryland Food Bank** https://mdfoodbank.org/	**MD Women, Children & Infants Program** https://phpa.health.maryland.gov/wic/Pages/Home.aspx Phone: 800-242-4942
Oregon	**Oregon SNAP Program** https://www.oregon.gov/DHS/ASSISTANCE/FOOD-BENEFITS/pages/index.aspx	**Partners for a Hunger Free Oregon** https://oregonhunger.org	**OR Women, Children & Infants Program** https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WIC/Pages/index.aspx Phone: 211

Virginia	**Virginia Dept of Social Services** https://commonhelp.virginia.gov/access/ Phone: 800-552-3431 (SNAP Hotline) **Virginia Hunger Solutions** http://vahungersolutions.org	**Virginia Food Bank Locator** www.vafoodbanks.org/covid-19-response/	**VA Women, Children & Infants Program** http://www.vdh.virginia.gov/wic/about/ Phone: 888-942-3663
Washington	**Department of Health Services** https://www.dshs.wa.gov/esa/community-services-offices/basic-food	**Washington Food Pantries** https://foodlifeline.org/need-food/	**WA Women, Children & Infants Program** https://www.washingtonconnection.org/home/
Washington, DC	**Commodity Supplemental Food Program (CSFP)** https://www.capitalareafoodbank.org/what-we-do/direct-food-distribution-programs/commodity-supplemental-food-program/ Phone: 202-644-9880 **DC Department of Human Services** https://dhs.dc.gov/service/snap-eligibility **DC Hunger Solutions** https://www.dchunger.org	**Capital Area Food Bank** https://www.capitalareafoodbank.org/find-food-assistance/ Phone: 202-644-9807	**DC Women, Children & Infants Program** https://dchealth.dc.gov/node/125192 Phone: 202-442-9397

Social isolation resources

SUMMARY OF KEY RESOURCES:

+ Curated list of digital resources as listed below. Resources are divided up into:

  • Supporting existing relationships with family and friends.

  • Building new relationships with people in their neighborhoods and communities (online and offline), which includes opportunities for virtual volunteering and group exercise classes.

  • Reframing relationships by restructuring one's cognitions.

  • Additional resources, which include links to community, mood, mental health, and technology help resources.

SUPPORTING AND MAINTAINING EXISTING RELATIONSHIPS

+ Given limitations to connecting with people in person, consider video calls, phone calls, and letter-writing.

  • **Zoom:** https://zoom.us/

  • **Skype:** https://www.skype.com/en/

BUILDING NEW RELATIONSHIPS

+ **Meet Up:** Online events covering a variety of topics and interests. https://www.meetup.com/

+ **Mocha Moms:** Support groups for mothers of color. www.mochamoms.org

+ **AARP Community Connections:** Find mutual aid or start your own mutual aid group. https://aarpcommunityconnections.org

+ **Village Network:** Become a member to volunteer or receive help. https://www.vtvnetwork.org/

+ **Friendship Line:** 24/7 access for emotional support and connection for seniors 60+. **800-971-0016**, https://www.ioaging.org/services/all-inclusive-health-care/friendship-line

+ **Healing Well:** online chronic illness support community. https://www.healingwell.com/

+ **Daily Strength:** online support groups by category. https://www.dailystrength.org/groups?all=true

+ **The Mighty Online Discussion:** online support groups for people facing health challenges. https://themighty.com/

+ **Virtual Volunteering**

  • **United Nations:** https://www.onlinevolunteering.org/en

  • **Smithsonian Digital Volunteers:** https://www.si.edu/volunteer/DigitalVolunteers

  • **Volunteer Match:** https://www.volunteermatch.org/

+ **Virtual Group Exercise Classes**

  • **List of 25+ Fitness Studios and Gyms Offering Free Workouts During COVID19:** https://www.goodhousekeeping.com/health/fitness/a31792038/coronavirus-live-stream-workout-classes/

  • **Free online yoga classes:** https://www.youtube.com/playlist?list=PLZkDZKOcvYTh4dRDXQ71m7gQUmWkDmLAl

REFRAMING RELATIONSHIPS

+ **Calm App:** Free resources available during this time without needing to make an account. https://www.calm.com/blog/take-a-deep-breath#meditations

ADDITIONAL RESOURCES

+ **Greater Good Science Center Practices:** https://ggia.berkeley.edu/

+ **Mental Health America:** https://mhanational.org/covid19

+ **Child Mind Institute:** https://childmind.org/coping-during-covid-19-resources-for-parents/

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+ **American Foundation for Suicide Prevention:**
  https://afsp.org/campaigns/covid-19/

+ **The Jed Foundation:**
  https://www.jedfoundation.org/covid19-tips-and-resources/

+ **NAMI:** https://nami.org/covid-19

+ **Active Minds:**
  https://www.activeminds.org/about-mental-health/be-there/coronavirus/

+ **KP Find Your Words:** https://findyourwords.org/

+ **Your Life Your Voice:**
  https://www.yourlifeyourvoice.org/Pages/home.aspx

+ **Loneliness-Specific Resources:**

  • **AARP Loneliness self-assessment and resources:** https://connect2affect.org/

Resources to help alleviate financial strain

OVERVIEW

+ For patients who are uninsured or are at risk of losing health coverage, suggest reviewing eligibility for health coverage through the health insurance exchange, Medicaid, or Children's Health Insurance Program (CHIP).

+ For patients experiencing loss of employment or income:

  - Suggest connecting to resources for accessing federal/state unemployment benefits, income support through cash-assistance programs like Temporary Assistance for Needy Families (TANF), employment assistance, payment for utilities, etc.

  - Suggest using a community-based certified financial counselor to help establish a personalized financial action plan.

Key resources include:

+ **Medicaid:** state coverage program for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Need to meet income and other eligibility requirements, which vary by state.

+ **Children's Health Insurance Program (CHIP):** coverage for low-income children, sometimes combined with a state's Medicaid program, with generally higher income limits than Medicaid. A child may qualify for Medicaid or CHIP even if the parent does not qualify.

+ **Health Benefits Exchange:** Exchange programs vary by state but generally provide premium assistance to eligible individuals and families on a sliding scale based on income, between 100 percent and 400 percent of the federal poverty level. To qualify for an exchange plan, a person must either have experienced a qualifying event or qualify for a special enrollment period.

FEDERAL UNEMPLOYMENT BENEFIT ENHANCEMENTS DUE TO COVID-19 – AMERICAN RESCUE PLAN ACT

Due to the economic downturn related to COVID-19, many individuals have lost wages and employment. New legislation was signed into law in March 2021 to extend pandemic-related federal unemployment benefits. Among other actions, the federal package:

+ Reinstates the federal increase for all unemployment benefits, which adds $300 to each week of benefits through September 6, 2021.

+ Extends Pandemic Unemployment Assistance and Pandemic Emergency Unemployment Compensation programs up to 53 weeks until September 6, 2021.

State employment departments are the point of contact as they carry-out the legislation once federal guidance is provided.

Accessing unemployment benefits by state

	State	🔍 Local Resource	📁 Resource/ Website
1	California	California Employment Development Department (EDD)	https://edd.ca.gov/claims.htm
2	Colorado	Colorado Department of Labor and Employment	https://cdle.colorado.gov/unemployment
3	Georgia	Georgia Department of Labor	https://cdle.colorado.gov/unemployment
4	Hawaii	Hawaii Department of Labor	https://labor.hawaii.gov/ui/
5	Washington, DC, Maryland, & Virginia	DC Department of Employment Services Maryland Department of Labor Virginia Employment Commission	https://does.dc.gov/service/unemployment-compensation-process https://www.dllr.state.md.us/employment/unemployment.shtml https://www.vec.virginia.gov/unemployed
6	Oregon	Oregon Employment Department	https://www.oregon.gov/employ/unemployment/pages/default.aspx
7	Washington	Washington Employment Security Department	https://esd.wa.gov/unemployment

Digital access resources

DIGITAL TECHNOLOGY

+ **Access from AT&T:** Low-cost internet service for eligible households based upon participation in SNAP, SSI in CA, income, and participation in school meal programs. https://www.att.com/internet/access/

+ **Comcast Internet Essentials:** New Comcast customers who are eligible for public assistance programs such as school meal programs, housing assistance, Medicaid, SNAP, SSI, and others. https://www.internetessentials.com/

+ **Cox:** Connect2Compete program new customers with at least 1 K-12 student in the household who qualifies for public assistance. https://www.cox.com/residential/internet/connect2compete.html

+ **FCC Enhanced Lifeline for Tribal lands:** Low-income on Federally recognized Tribal lands. https://www.lifelinesupport.org/

+ **Lifeline:** A Federal Communication Commission Program that provides discounted phone or internet service for eligible low-income subscribers, based upon 135% federal poverty guidelines; participation in benefit programs including SNAP, Medicaid, SSI; or some residents of tribal lands. https://www.lifelinesupport.org/

+ **Mediacom:** Connect2Compete Program. Internet service for New Mediacom customers with at least one K–12 student in household who qualifies for National School Lunch Program. https://mediacomc2c.com/

+ **Spectrum:** Internet Assist Program provide internet service for eligible households where at least one member of the household is the recipient of public assistance. https://www.spectrum.com/browse/content/spectrum-internet-assist

+ **Verizon:** Fiber Internet Program - New Verizon customers who are enrolled in the Lifeline Discount. https://www.verizon.com/info/low-income-internet/

+ Local communities may offer free internet access from libraries, community centers and parks.

COMPUTERS & SMARTPHONES

+ **Computer Reach:** Refurbished equipment, computer literacy, training and support. https://www.computerreach.org/who-we-are/about-us/

+ **Computer & Technology Resource Center:** Free refurbished computers to low income individuals, schools and non-profit organizations in need. https://ewastecollective.org/free-computer/

+ **PCs for People:** Refurbished desktop and laptop computers for eligible recipients. https://www.pcsforpeople.org/

DIGITAL LITERACY TRAINING

+ **American Library Association:** works to extend and expand library services—connecting residents with digital literacy training and free print and digital resources that support learning, employment and creativity for all ages and interests. http://www.ala.org/pla/initiatives/digitalliteracy

+ **Common Sense:** Promotes safe use of technology and media. Reviews and rates digital and print media. https://www.commonsense.org/education/connecthome

ASSISTIVE TECHNOLOGY

+ **National Deaf Blind Equipment Program:** Offers digital equipment devices for persons with disabilities. http://www.icanconnect.org/equipment

+ **The Arc (Partnership with Comcast NBCUniversal):** The Arc's technology programs are designed to increase the effective adoption of technology by people with intellectual and developmental disabilities and support technology companies to create accessible and usable products for people with intellectual and developmental disabilities. https://thearc.org/our-initiatives/technology/

Resources for seniors

FAMILY CAREGIVER SUPPORT AND RESPITE

Family caregivers living with and caring for at-risk seniors have particular needs, including information about respite options while sheltering-in-place, advice on how to maintain their own mental and physical health while providing care, options for managing when senior centers, adult day centers, and other resources are unavailable, and how to access health care for themselves and their loved ones.

+ **Family Caregiver Alliance:** Online and telephone support available to family caregivers of people living with dementia or other cognitive conditions. Virtual support groups, family counseling, assistance managing variety of condition-related behaviors, caregiver how-to videos, and variety of disease-specific and other fact sheets available. **800-445-8106**, www.caregiver.org

+ **Caregiver Action Network:** Free online and telephone support for COVID-19-related family caregiving issues. **855-227-3640**, www.caregiveraction.org

+ **COVID-19 Caregiving:** Free online blog posts specific to caregiving issues during COVID-19 pandemic. https://covid19caregiving.com

FOOD INSECURITY

Includes trouble obtaining groceries, closure of meal sites like adult day health centers and/or PACE sites, affording food. Senior-specific resources include the below. (See Food Insecurity section for more information.)

+ **Eldercare Locator:** Enter zip code and will list senior-specific food resources. https://eldercare.acl.gov/Public/Index.aspx

+ **Meals on Wheels:** Committed to continuing delivery of food to homebound older adults, enter zip code to find out what is offered in nearly every community. https://www.mealsonwheelsamerica.org/

+ **Moms Meals:** Provides tailored meals. Note that KP has existing contracts with Moms Meals in

some areas - inquire about local arrangements. **877-508-6667,** https://www.momsmeals.com/

+ **(California Only) Great Plates Delivered**: Federal Emergency Management Agency (FEMA)'s public assistance program that provides meals for seniors and other adults at high risk of COVID-19. https://covid19.ca.gov/restaurants-deliver-home-meals-for-seniors/

HOUSING

For senior-specific housing needs, contact the below number: (See Housing Insecurity section for more information.)

+ **Eldercare Locator:** Lists senior-specific housing resources. **800-677-1116**, https://eldercare.acl.gov/Public/Index.aspx

PLANNING AHEAD/ADVANCE CARE PLANNING

It is especially important for patients to think about and identify who they would want to speak for them should they become unable to do so for themselves due to a medical condition or situation (e.g., severe COVID-19). They should also decide what types of care are desired or not. Issues for patients to consider:

+ Do you have an identified health care agent or proxy?

+ Do you have an advance directive? Does your physician have a copy?

+ If you have not yet thought about or documented your wishes, there are a variety of easy-to-follow tools to assist you:

  • Videos, step-by-step instructions and state-specific advance directives available for download: https://prepareforyourcare.org/

SAFETY

For senior-specific, safety-related topics, including elder abuse and fraud:

+ **Eldercare Locator**: Lists senior-specific safety resources. **800-677-1116**, https://eldercare.acl.gov/Public/Index.aspx

SOCIAL ISOLATION

As with anyone, older adults benefit from connections with family, friends, work colleagues, neighbors and people calling to check in. Consider having someone help elderly patients set up and explain how to use FaceTime, Zoom, or other video-enabled tools, so they can see and interact with friends and family while sheltering in place. Neighborhood volunteer programs can bring (and wipe down as they hand over) books, puzzles, or DVDs. Listening to favorite stations on the TV or radio can help with loneliness. (Suggest limiting time watching or scrolling through news sites, especially before bedtime.) Below are senior-specific resources to share with patients: (See Social Isolation section for more information.)

+ **Friendship Line**: Provides 24/7 phone access for emotional support and connection. **800-971-0016**, https://www.ioaging.org/services/all-inclusive-health-care/friendship-line

+ **Village to Village Network:** Hyper-local member/volunteer villages organized to help reduce isolation and increase independence. Villages are actively reaching out to people to check in on them during COVID-19 event. **617-299-9NET,** https://www.vtvnetwork.org/

STAYING ACTIVE

Exercise is especially beneficial to older adults. It can help improve and maintain muscle strength, balance, mood, and overall quality of life. Encourage daily activity geared toward the person's capabilities and interests. Encourage patients to look around their homes to find ways to do strength-based exercises like lifting or curling hand weights or soup cans, using elastic-resistance bands, and dancing. Yoga and stretching exercises can be done at home with poses adapted for all ages and abilities. Many yoga and Pilates studios and gyms, like the YMCA, are offering free, guided sessions online through Zoom, YouTube and Facebook, which can be streamed to a laptop, iPad, or TV. Gardening and light housework are likewise sources of exercise when tailored to one's abilities.

Examples include:

+ **National Institute on Aging:** Free15 minute online exercises (YouTube). https://www.youtube.com/watch?v=Ev6yE55kYGw

+ **SilverSneakers OnDemand:** https://www.silversneakers.com/learn/ondemand/

+ **YMCA of San Francisco:** Virtual classes including meditation. **415-777-9622**, https://www.ymcasf.org/virtual-classes

TECHNOLOGY AND COMMUNICATION

Some seniors might not have access to smartphones, computers, or the internet, so creative options and local resources might be needed:

+ **Eldercare Locator**: List of technology resources. **800-677-1116**, https://eldercare.acl.gov/Public/Index.aspx.

+ **Consumer Cellular (AARP):** Discounted monthly cellular service. https://www.consumercellular.com/AARP

+ **Lively Mobile Plus:** Personal Emergency Response System (PERS). https://www.greatcall.com/devices/lively-mobile-medical-alert-system

+ **Older Adults Technology Services:** https://oats.org/approach/

+ **Oscar Senior:** For health care to connect with seniors. https://www.oscarsenior.com/how-it-works

TRANSPORTATION

Use available resources to facilitate transportation for essential medical visits (i.e., for issues not able to be resolved virtually by phone or computer). Additional community-based resource:

+ **Eldercare Locator:** Lists senior-specific transportation resources. **800-677-1116** https://eldercare.acl.gov/Public/Index.aspx